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IN THE

Supreme Court of the United States

OCTOBER, 1975

No. 75-1041

MT. SINAI HOSPITAL OF GREATER MIAMI, INC., *Petitioner*

v.

FORREST D. MATHEWS, SECRETARY OF HEALTH, EDUCATION & WELFARE, AND BLUE CROSS OF FLORIDA, INC., *Respondents*

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Mt. Sinai Hospital of Greater Miami, Inc. (Mt. Sinai) petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit entered in this cause on August 8, 1975.

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[1] At the time this case was originally filed, Caspar Weinberger was the Secretary of Health, Education and Welfare and hence was a named Defendant; he has since resigned and his successor is named as Respondent herein.

DECISIONS BELOW

The initial opinion of the Court of Appeals (Appendix, pp. 1a-26a) is reported at 517 F.2d 329; its opinion on Mt. Sinai's Petition for Rehearing (Appendix, pp. 27a-28a) is reported at 522 F.2d 179. The Court of Appeals reversed the decision of the United States District Court for the Southern District of Florida, whose opinion is reported at 376 F. Supp. 1099.

JURISDICTION

The judgment of the Court of Appeals was entered on August 8, 1975. On August 22, 1975, Mt. Sinai filed a Petition for Rehearing and Petition for Rehearing *en banc*. These petitions were denied by the Court of Appeals on November 3, 1975. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND CONSTITUTIONAL PROVISIONS INVOLVED

This case involves the Medicare Act, which is Title XVIII of the Social Security Act. [42 U.S.C. 1395 through 1395pp, and 1320c through 1320c-19.] The Medicare Act became effective on July 1, 1966 and, as of the time this controversy arose in 1973, the Medicare Act had been amended in October 1972. Also involved is the Fifth Amendment to the United States Constitution. The pertinent Constitutional and statutory provisions are set forth in the Appendix hereto at pp. 29a to 38a.

THE PARTIES AND THE NATURE OF THE DISPUTE

Mt. Sinai has, for many years, been a general and nonprofit hospital. When the Medicare Act became effective on July 1, 1966, many of Mt. Sinai's patients

became, and over the years have been, Medicare beneficiaries entitled to hospital insurance under that program. The Medicare Act is administered by the Secretary of the Department of Health Education & Welfare ("HEW") through its Social Security Administration, acting in conjunction with private insurance companies known as intermediaries—in this case, Blue Cross of Florida, Inc. ("Blue Cross"). This injunction suit was instituted by Mt. Sinai against Respondents HEW and Blue Cross to enjoin them from withholding more than $6.38 million of Medicare payments to which Mt. Sinai would be entitled. The District Court entered a permanent injunction; the Court of Appeals reversed. The dispute herein arose as follows.

In 1973, Respondents advised Mt. Sinai that they would begin immediately to withhold a portion of all subsequent Medicare payments otherwise due to Mt. Sinai, until they thereby recouped from the hospital a total of $6,380,587.49. According to Respondents, this amount represented the total of a statistically computed fixed percentage of each of the many thousands of separate Medicare payments made to Mt. Sinai throughout the July 1, 1966 to December 31, 1971 time period. Respondents contended that this $6,380,587.49 represented the amount which they statistically computed as having been paid to Mt. Sinai, during those five and one-half years, for services which were medically unnecessary, and, as a result, Respondents contended that they had the power to recoup those funds.

During the July 1, 1966 to December 31, 1971 time period, the medical services provided by Mt. Sinai to Medicare patients were those prescribed by physicians;

and, in each instance, the judgment of the physician as to the medical necessity of the prescribed treatment was subject to review by Respondents on a prepayment basis. Although, as required by the Act, every one of these many payments (totaling $6.38 million) had been originally approved by Respondents on a case-by-case basis throughout the said five and one-half years, Respondents nevertheless contended below that they have the *perpetual* right to repudiate those prior approvals at any time, to recoup from the hospital any payments which Respondents might now deem to have been previously made for unnecessary medical services, and to effect that recoupment by unilaterally withholding otherwise due funds, from the hospital, without the hospital having the right to either an administrative hearing or judicial review.

While the $6,380,587.49 relates to the period from July 1, 1966 to December 31, 1971, Respondents also threatened to make the same kind of statistically based determination, and thereupon to recoup funds, for years after 1971; but since Respondents contended that there is no time limit on their right to make such a determination and thereupon to withhold otherwise due funds, that computation for post-1971 periods had not yet been made when this suit was filed.

The basic dispute is whether hospitals may rely on HEW's inital determinations that the hospital services, prescribed by attending physicians, were medically necessary and therefore covered by Medicare—*i.e.,* to be paid by the patients' Medicare insurance rather than by the patients themselves. If, after years of participation in the Medicare program, hospitals are to learn that they cannot so rely and that all prior payment decisions are forever subject to change on the

subjective and judgmental grounds of medical necessity, all of the many thousands of Medicare providers will be forced to exist under the perpetual threat of a unilaterally implemented administrative recoupment of staggering proportions; and when that threat materializes, as it did for Mt. Sinai, those hospitals may be forced not only to refund overwhelming sums of money to which they were originally entitled, but also to become the ultimate insurer of the patients who received the services at the instructions of their attending physicians.

QUESTIONS PRESENTED

This dispute, the nature of which has been described immediately above, involves the following questions which are of a contining nature and which govern one of HEW's key functions in administering the Medicare program:

1. Where a hospital follows the instructions of attending physicians and provides medical services to Medicare patients, thereby becoming entitled to payment from either the patients or their insurer Medicare; where HEW is required by the Medicare Act to determine, before payment, whether the services were medically necessary and thus covered by Medicare insurance; and where HEW approves and makes Medicare insurance payments for all or part of the patients' hospital bills, does HEW have the implied power, exercisable at any time perpetually thereafter as the Court below held,

(a) to repudiate its prior payment determinations;

(b) to make a postpayment determination or redetermination that the hospital services, pre-

scribed by the physicians, were medically unnecessary;

(c) to claim, from the hospital, a refund of the payments made for those services; and

(d) to satisfy its claim by withholding other funds unquestionably due to the hospital?

2. If HEW has the implied power to repudiate its prepayment determinations and to make a postpayment determination that previously paid for hospital services were medically unnecessary, may it make such a postpayment determination without complying with the express statutory and regulatory requirements applicable to the making of such a determination before payment?

3. If a hospital may ever be liable for the refund of Medicare payments where the sole basis is a postpayment determination that an attending physician prescribed medically unnecessary services, may that liability be administratively determined and then satisfied administratively by recoupment, when the result is to deprive the hospital of its right to pursue reimbursement from the patient and thus to make the hospital the ultimate insurer of the costs of the prescribed services?

4. If, as the Court below held, a hospital, under the circumstance here involved, may be forced to refund Medicare payments even if it has no right to pursue reimbursement from the patient, does this loss of funds, to which the hospital was originally unquestionably entitled, constitute a deprivation of property without due process of law in violation of the Fifth Amendment?

5. Does the Medicare Act violate a hospital's Fifth Amendment rights if it impliedly authorizes such a recoupment power without also providing a hospital with procedural due process safeguards?

STATEMENT OF THE CASE

A. Introduction

As more fully set forth in the REASONS FOR GRANTING THE WRIT *infra*, not only is the decision below erroneous, but the ramifications of that decision, involving substantial public interest questions, go far beyond this one case and have a direct and virtually incalculable impact upon the administration, feasibility and success of one of this country's major domestic programs—Medicare.

As indicated in the decisions of both Courts below, the questions herein cannot be answered on the basis of the language or interpretation of any one particular section of this lengthy, complex and, in certain respects, ambiguous Medicare Act. Instead, the answers require a difficult interpretation of a number of interrelated sections of the Act, against the background of the structure of the Act, its purposes, legislative history and practical effects.

Although the present case involves payment years which fall under the Medicare Act as originally enacted rather than as amended in October 1972, the issues herein are of a continuing nature. First, neither HEW nor the Court below recognized any time limitation on recoupments from hospitals. Therefore, all hospitals are under a continuing threat of recoupment in future years based on payments received from the inception of Medicare until at least the end of 1971. Second, since

the Fifth Circuit found an implied recoupment power outside the Medicare Act, there is an unresolved question whether such power can co-exist with the October 1972 amendments for periods either before or after 1972. For itself, HEW has answered this question by expressly threatening to pursue the same contested course of action against Mt. Sinai not only for the period of the first 10 months of 1972, but also for periods thereafter. [R. 106-107.]

Consequently, not only does the erroneous decision below have a staggering direct impact upon Mt. Sinai, but the decision will also determine how a basic aspect of the Medicare program will be administered nationally in the future. It is no exaggeration to say that, for HEW, *Mt. Sinai* is a test case. If the Fifth Circuit's decision stands, recoupment will become an unexpected and disabling consequence of Medicare participation for hospitals across the country.

B. The Medicare Act

Medicare is a national health insurance program which, since its inception on July 1, 1966, has covered eligible beneficiaries, namely persons aged 65 and over; since 1973, it has also covered disabled persons. [42 U.S.C. 426(a) and 1395c.] The Act is divided into two parts: under Part A, the eligible beneficiaries are insured for hospital and related post-hospital services [42 U.S.C. 1395c-1395i-2], which insurance is funded through payroll deductions contributed to the Federal Hospital Insurance Trust Fund [42 U.S.C. 1395i]; under Part B, the supplementary medical insurance program, eligible persons are insured for other medical services such as those of physicians, but this insurance coverage is optional and requires the beneficiary to

enroll in the program and pay a monthly insurance premium which is matched by a federal contribution. [42 U.S.C. 1395o-1395s.] This case involves questions concerning the substantive and procedural rights and relationship between hospitals and HEW under Part A of the Medicare Act.[2]

The Medicare Act does not relieve an eligible beneficiary of his personal obligation to pay for medical services which he receives; Medicare, as the insurer, merely pays to, or for the benefit of, the patient a part of that patient's medical expenses, and the patient must pay the balance. For example, under Part A, if a Medicare patient is hospitalized for a covered service, there are certain amounts in the nature of deductibles or co-insurance which Medicare will not pay [42 U.S.C. 1395e]. There are also limits in terms of the maximum number of hospital days (150 per illness) which Medicare will cover [42 U.S.C. 1395d]; and if the services rendered were of the type not covered by insurance [42 U.S.C. 1395y], Medicare has certain rights not to pay.

In order to effectuate the claims and payment process, the hospital submits the appropriate insurance forms to HEW through the latter's intermediary. Before payment, HEW and its intermediary are required to process those forms and determine whether the patient is eligible for insurance, the amount of insurance to which he is entitled and whether the services rendered were covered by insurance, including whether they were medically necessary. [42 U.S.C. 1395ff(a); 20

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[2] The case at bar was argued to, and decided by, the Court of Appeals concurrently with the case of *Szekeley* v. *Weinberger*, 517 F.2d 345, a Part B case involving a physician and wherein the Court below reached the same result.

C.F.R. 405.701 *et seq.*] To the extent HEW approves payment, such payment, though made directly to the hospital, is deemed by the Medicare Act to have been made to the patient. [42 U.S.C. 1395gg(a)(1)(A).] The patient, therefore, is the beneficial recipient of that payment since it is his insurance paying his bill, and it is his debt to the hospital which is being satisfied *pro tanto*.

Moreover, a hospital may bill, and receive payment for, no more than the cost of the covered services provided to a Medicare patient. [42 U.S.C. 1395f(b) and 1395x(v).] [3] Once HEW determines that the service is covered and that a Medicare payment is to be made therefor, the hospital must accept that payment from HEW and may not bill the patient except for the amounts not paid by HEW for that service, such as the deductible and co-insurance amounts noted *supra*. [42 U.S.C. 1395cc(a)(1)(A).]

If HEW refuses to pay for all or any part of the patient's hospital bill, the patient, since he must pay the hospital, has the right to contest with HEW the refusal to pay; in this regard, the patient (but not the hospital) has the right to an adversary type administrative proceeding if more than $100 is involved and to judicial review if more than $1000 is involved. [42 U.S.C. 1395ff(b).]

C. Statement of Facts

Mt. Sinai has been a qualified provider since the July 1, 1966 effective date of Medicare. It is a general

[3] After the close of the hospital's fiscal year, a cost audit is performed to determine if the hospital's costs for Medicare services equaled the payments made therefor; if not, an adjustment is made to equalize the two. [42 U.S.C. 1395g.]

and nonprofit 646-bed hospital and, as the record reflects, has operated at a substantial loss, relying heavily on donations. [R. 306.] [4, 5] Not only is it one of the largest hospitals in the Southeast, but it is located in an area (Miami Beach, Florida) heavily populated by persons eligible for Medicare; it also specializes, and enjoys a national reputation for leadership, in, *inter alia*, medical fields relevant to the problems of persons aged 65 and over and hence serves Medicare patients referred from other areas of the United States. [R. 5, 6]. Consequently, a large percentage of its patients has consisted of Medicare beneficiaries. [R. 304.]

During the entire period from July 1, 1966 to the present, Mt. Sinai has provided to Medicare patients the services prescribed by the patients' attending physicians. As a qualified Medicare provider, it submitted insurance forms and information to HEW through the latter's intermediary, Blue Cross. Those forms were then processed by Respondents; to the extent approved, the reimbursement claims were paid to Mt. Sinai by HEW [R. 9, 22], which payments, as noted, were only for the cost of the rendered services.

In the Spring of 1973, HEW made a demand upon Mt. Sinai to refund $6,380,587.49 from the Medicare payments which had been made by HEW to Mt. Sinai for services during the entire period from July 1, 1966

[4] Mt. Sinai's 1972 loss was $946,638, and it had budgeted, for 1973, a loss of $1,933,176. (R. 306)

[5] References to "R" are to the record appendix which was before the Court below. While those record references are not reproduced in the Appendix to this Petition, the references have been inserted in order to alert Respondents to the specific portions of the record relied on by Petitioner in asserting the facts herein.

(the first day of Medicare) through December 31, 1971. HEW also stated that it would demand an additional refund for post-1971 time periods, but that the amount had not yet been calculated. [R. 106-107.] To effect this refund, HEW advised that it would begin holding back a percentage of Medicare payments otherwise unquestionably due to Mt. Sinai for future, current and recently provided, but unpaid for, services until the full $6,380,587.49 was recouped. [R. 34, 106-107.]

In making this demand, HEW did not contend that Mt. Sinai had committed any fraud. Nor has HEW contended that Mt. Sinai made any misrepresentations of fact in submitting insurance forms and receiving payment. Moreover, it is admitted that Mt. Sinai rendered every service for which it was paid and that it has been paid no more than the correct amount, namely the cost of those services rendered to Medicare patients at the physicians' instructions. The only basis for HEW's demand is its contention that a part of the services rendered to Medicare patients was medically unnecessary.

HEW does not contend that the hospital could or should have refused to provide the services prescribed by the patients' physicians. Instead, the thrust of HEW's position is that it was an error in medical judgment for the physician to have prescribed certain hospital services, that it was, in turn, an error for HEW to pay for those services and that HEW should now have the power, years later, to reopen all cases going back to July 1, 1966 without limitation as to time or amount, contradict the initial medical judgment made by the physican and reclaim, from the hospital, the amounts paid for those services, even though the hospital was unquestionably entitled to such payment, whether from the patient of Medicare.

HEW's demand for a refund of $6,380,587.49 was based on a determination which was made by it and Blue Cross, essentially *in camera*. In two separate sessions, one in December 1972 and the other in January 1973, a group of unidentified doctors reviewed the charts of 710 patients who had been hospitalized at Mt. Sinai in 1970, which charts did not contain the patients' complete medical records. According to HEW, these doctors (without consulting the patients, the patients' other medical records, the attending physician or the hospital) spent an average of 10 to 15 minutes reviewing each such chart, and, without any guidelines from HEW as to the legal standards to be applied under the Medicare Act, concluded that a portion of the hospital services prescribed for 283 of these patients was unnecessary, which services were essentially the tailend days of the hospital stays. [R. 133-136, 158, 167.] Arriving at an arithmetical percentage of alleged unnecessary services to total services for those selected patients in 1970, HEW then applied that percentage across the board to all the services rendered to all (more than 62,800) Medicare patients treated by Mt. Sinai from July 1, 1966 to December 31, 1971, which percentage it priced at $6,380,587.49. [R. 12, 98, 138.]

When Mt. Sinai asked for the pertinent information relating to these conclusions, such as the identities and qualifications of the physicians who allegedly determined that a portion of the services were unnecessary, as well as the facts on which the decisions were based, HEW absolutely refused to give the information [R. 35-38, 52-53, 127, 135, 137.] In addition, Respondents admitted that they had never gone through another procedure quite parallel to that followed with respect to Mt. Sinai [R. 122] and that they did not know

everything that had been done during the so-called review [R. 123]; and just as they refused to discuss in any way the basis of the medical determinations [R.168-169], Respondents refused even to say whether or not they had a full understanding of the methodology used. [R. 170-171.]

While Mt. Sinai and the Respondents had two informal meetings, which HEW elects to call hearings, the following statement by a representative of the Respondents, when he was asked during a meeting for meaningful information relating to HEW's claim, is typical of the totally uncommunicative position taken by Respondents [R. 182].

> . . . I don't want to repeat myself, but again we have not come here today to be questioned by Mt. Sinai. The purpose of this meeting is not to furnish information for Mt. Sinai to make a determination.

Mt. Sinai attempted to rebut HEW's position [R. 39-48, 332-348], but it was to no avail. Respondents refused to provide an administrative hearing, denied that judicial review was available and threatened to withhold funds starting immediately until the full $6,380,587.49 was recouped, notwithstanding the fact that this approach totally circumvented the prepayment review procedures established by 42 U.S.C. 1395ff and 20 C.F.R. 405.701 *et seq.*

Given HEW's threat and mode of proceeding, Mt. Sinai filed suit on May 10, 1973 to enjoin the withholding of funds admittedly due to and urgently needed by it to continue the level of medical services it was then providing already at a loss. Mt. Sinai's attempt, through discovery, to ascertain the facts underlying HEW's actions came to naught after HEW objected

thereto on the grounds that the legal issue, i.e., whether HEW had the power it was asserting, could be decided without inquiry into the facts. After an evidentiary hearing, the District Court found that the threatened withholding of funds would cause immediate and irreparable harm not only to the hospital but also to the public because of the potential curtailment of medical services that a withholding of funds would cause.[6] The District Court also held that the statutory procedures set forth in the Medicare Act provided the sole and exclusive means for HEW to make coverage determinations and payment adjustments, and that nothing in the Statute authorized HEW's threatened retroactive recoupment of funds from Mt. Sinai. Accordingly, it permanently enjoined HEW from the threatened withholding action.

The Court of Appeals reversed, holding that the Medicare Act *impliedly* empowered HEW to recoup funds from a hospital, even if the only basis for such recoupment was a new judgment as to the medical necessity of treatment prescribed years before; and it held that this implied power was not affected by the Medicare Act, even though that Court acknowledged that the exercise of such power was inconsistent with certain provisions of the Act itself.

REASONS FOR GRANTING THE WRIT

A. The Importance of the Issues

The decision of the Court below is an erroneous interpretation of the Medicare Act and permits a result which, in violation of the Fifth Amendment, puts Mt.

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[6] See fn. 4, p. 11, *supra*. Given Mt. Sinai's negative cash flow there was testimony before the District Court that the threatened withholding of funds by HEW would have a catastrophic effect on the hospital and its ability to provide services. [R. 220.]

Sinai in jeopardy of losing more than $6.38 million in Medicare reimbursements to which it is entitled by law for the cost of services rendered to Medicare beneficiaries. But beyond the $6.38 million effect on Mt. Sinai, the decision below will have a profound impact upon the administration and operation of Medicare nationally.

The basic dispute is whether, in administering the Medicare program, HEW must follow the procedures that are expressly established under the Medicare Act, and which attempt to balance the competing substantive interests of Medicare beneficiaries, Medicare providers and Medicare insurance funds under procedural due process safeguards; or whether HEW may, on a common law recoupment theory, circumvent the procedures and totally upset that balance by creating a system of retroactive review and recoupment which is neither expressed in, nor consistent with, the Act.

The Fifth Circuit, by implication, found a non-statutory power, under which power HEW may forever into the future contest the medical necessity of hospital treatment provided as far back as July 1, 1966, and then reclaim, from hospitals, the amounts attributable to the allegedly unnecessary services which the hospital did no more than provide, pursuant to the orders of an attending physician. This power, with its *perpetual* threat to hospitals, creates an immense area of potential uncertainty and dispute under the Medicare program generally. For the period from July 1, 1966 through 1971 alone, thousands of hospitals, millions of patients and billions of dollars will forever be subject to this power, as the following statistics reflect:[7]

[7] These statistical charts are derived from data provided by HEW and from HEW's published annual reports on the Medicare program.

FOR THE UNITED STATES[8]

Year	Eligible Beneficiaries[9]	Participating Hospitals[10]	Medicare Payments[11]
1967	19,022,707	6,750	$2,192,341,502
1968	19,309,572	6,753	3,066,963,782
1969	19,586,536	6,712	3,712,775,897
1970	19,838,866	6,670	4,246,048,000
1971	20,230,121	6,642	4,808,831,000
Total 1967-1971			$18,026,960,181

Even if the decision below were viewed as affecting only the Medicare program as administered in the Fifth Circuit, the potential impact of the Court of Appeals decision is immense, as indicated by the following data:

FOR THE FIFTH CIRCUIT[12]

Year	Eligible Beneficiaries	Participating Hospitals	Medicare Payments
1967	2,827,651	1,169	$260,222,005
1968	2,888,783	1,178	396,856,915
1969	2,972,555	1,194	480,787,064
1970	3,053,286	1,184	582,096,000
1971	3,177,390	1,212	659,765,000
Total 1967-1971			$2,379,726,984

[8] Not including outlying possessions.

[9] As of January 1 of each year, except for 1967, which covers the 18-month period from July 1966 through December 1967.

[10] As of July 1 of each year.

[11] By fiscal year, based on interim reimbursements, for short-stay in-patient hospital benefits.

[12] Compiled from statistics reported for the States of Alabama, Florida, Georgia, Louisiana, Mississippi and Texas.

Every one of the hospitals, hospital patients and dollars involved in Medicare through the end of 1971 is therefore subject to the unlimited power found to exist by the Court below. Given the above statistics, the potential for perpetual controversy is awesome. The sheer administrative effort and financial resources needed to assert and contest retroactive recoupment claims will be enormous, as will be the disruptive effect, regardless of how such claims against hospitals are eventually resolved. And the financial impact of such a recoupment campaign, in which Mt. Sinai stands as the test case, could be devastating for hospitals generally, as well as result in the hospitals being financially unable to maintain the level or scope of services required by the public. [R. 61, 244.]

The mere continuing threat of massive recoupment (which the decision below permits) nullifies reliance on past medical judgments already approved, makes hospital planning and budgeting difficult, if not impossible, and could well discourage hospitals from future participation in the Medicare program, because of the inordinate and uncontrollable financial risk involved.

The October 1972 amendments added to the Medicare Act a number of important changes, among which were the additions of 42 U.S.C. 1395pp and an addition to the then existing 42 U.S.C. 1395gg. The open question is whether these 1972 additions create a new and greater exposure on the part of hospitals or whether they create an exposure in addition to, or in limitation of, a common law recoupment right which the Court below found to be impliedly permitted by the original Act. This question is further complicated by the addition of 42 U.S.C. 1320c through 1320c-19 which established the so-called Professional Standards Review Organization ("PS

RO") and which relate to the question of handling medical necessity questions *vis-a-vis* the hospital. [42 U.S.C. 1320c-9.]

The Court below failed to come to grips with the interrelationships of these various sections, leaving in doubt the question of where ultimate exposure resides, and its simplistic reliance on an alleged common law recoupment theory creates confusion and hence uncertainty. As noted, *supra*, p. 6, HEW has threatened to apply the same technique against Mt. Sinai for years after 1971, indicating that the October 1972 amendments to the Medicare Act do not, in HEW's view, affect the common law recoupment power held by the Fifth Circuit to be implied in the Medicare Act.

The decision below, therefore, has extensive and continuing ramifications for the period prior to the 1972 amendments, and it has created inconsistencies and uncertainties relative to the present and future administration of the Act under the 1972 amendments.

B. The Decision Below Is Erroneous

1. The Medicare Act neither expressly nor impliedly permits HEW, on a common law recoupment theory, to recover funds from a hospital, solely on the basis of a retroactive determination by HEW that hospital services, previously prescribed by physicians and paid for by Medicare, were medically unnecessary.

Both Courts below recognized that the Medicare Act nowhere *expressly* authorizes HEW to do as it threatened here. The Court of Appeals, however, held that a power to recoup from a hospital was *impliedly* authorized by the Act, and, in so doing, that Court disregarded the authoritative statements of Government representatives to the effect that *no* such power exists. For example, testifying before Congress in 1970, Social Security Administrator Ball stated that HEW (absent

of course fraud or other independent claim) had no such power under Medicare, even for abuses of the program, and that its power was limited to a case by case prepayment review. See Hearings on H.R. 1 before the Committee on Ways and Means of the House of Representatives, 91st Cong., 2d Sess. 154 (1970). The House Ways and Means Committee stated that same conclusion in 1970 [H. Rep. No. 91-1096, 91st Cong., 2d Sess. 43 (1970)] and in 1971 [H. Rep. No. 92-231, 92d Cong., 1st Sess. 98-100(1971)] as did the Senate Finance Committee in 1972 [S. Rep. No. 1230, 92d Cong., 2d Sess. 200 (1972)]. The Justice Department, in its Brief to the Second Circuit in *Kingsbrook Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973), made the same representation as to Congresssional intent when it stated:

> *Nor would it be reasonable to assume that Congress intended to keep open all accounting periods and to continually change the amounts for past years to which a provider was entitled.* Moreover, a change in HEW's policy or regulations would not necessarily mean that a provider would be entitled to additional money; it may well be that the change could yield an "overpayment" for a particular prior year—indeed, it appears that in this case appellant did receive an "overpayment" in 1966 if the change is retroactively applied. *Congress could not have intended to put providers in continuing jeopardy of having to return potentially large sums of money previously determined to be due them.* (Brief, pp. 26-27) (Emphasis supplied.) [13]

[13] *Kingsbrook* was a cost accounting case, not a case involving coverage questions such as medical necessity. There are different statutory provisions dealing with cost accounting and which allow certain retroactive accounting adjustments for determining the total cost for which a hospital may be reimbursed. However, Justice's reference to Congressional intent is applicable to coverage cases as well.

In addition to the above statements, that no such power exists, HEW itself could not find a proper source for the recoupment power it asserts here. Although Medicare became effective on July 1, 1966, it was not until May 1972 (almost six years later and on the eve of the 1972 amendments) that HEW first promulgated a regulation expressing the right to recover funds, and, in so doing, it did not rely on any common law recoupment power.[14] The only substantive authority on which HEW predicated its authority was 42 U.S.C. 1395g which, as *both* Courts below held, *did not* authorize the recoupment right asserted by HEW. Not until HEW's action was challenged by Mt. Sinai, in what has become a test case, did the Justice Department urge the common law as an alternative source of HEW's asserted recoupment power. In view of the fact that HEW waited so long to express such a recoupment power by regulation and then was unable properly to locate the source of that power, there is all the more reason to doubt the very existence of that power which the Court below could find only by implication.

And even the Justice Department, in making its common law recoupment argument below (contrary to its argument in *Kingsbrook*), was internally inconsistent and hence inconclusive as to what the Medicare Act impliedly provides. For example, in its Opening Brief below (p. 24), the Justice Department argued that HEW *was not required* to recoup funds previously paid for unnecessary services, while later in the same Brief (p. 33), it argued that HEW *was required* to recoup

[14] 37 Fed.Reg. 89 (Jan. 5, 1972), proposing adoption of 20 C.F.R. 405.370 *et seq.* The regulations were adopted as proposed. 37 Fed. Reg. 10722 (May 27, 1972).

such funds. Such inconclusiveness, like HEW's erroneous view of the source of its power, does little to engender confidence in the correctness of HEW's present position and the decision below, especially in view of the contrary pronouncements noted, *supra*.

The Fifth's Circuit's decision is also inconsistent with, and violative of, certain express provisions in the Act itself. While the decision below assumes that HEW must be able to avoid, at all costs, paying for any service which is medically unnecessary, the Act contemplates otherwise. For example, under the Act, a hospital must maintain an in-house utilization review committee of physicians to establish procedures for avoiding unnecessary care.[15] If that committee determines that a particular hospital stay for a patient is no longer necessary, it is required to notify the hospital and the patient's physician. [42 U.S.C. 1395x(k)(4).] Even after such a determination and notice, Medicare hospital benefits are still to be paid by HEW up to the fourth day following the hospital's receipt of that notice. [42 U.S.C. 1395f(a)(7).] Under Medicare, therefore, it is erroneous to start with the assumption that any payment for an unnecessary service can and must be recouped; yet HEW and the Court below not only start with this assumption, but, by retroactive recoupment, they would even wipe out, by implication, the statutory grace period by recouping funds paid for

[15] Ironically, Mt. Sinai's committee, during the years here involved, had not only been praised by Respondents but was referred to as a paragon for other hospitals to emulate. [R. 8-9, 22, 43-44] For a description of the role of in-house utilization review, see *Hultzman* v. *Weinberger*, 495 F.2d 1276 (3rd Cir. 1974).

every allegedly unnecessary day at the hospital, and without any prior notice at all.[16]

As further evidence that it did not intend to make make hospitals retroactively accountable for the medical judgments of attending physicians, Congress provided that the patients' hospital claims be reviewed by HEW before payment on a current and case-by-case basis. [42 U.S.C. 1395ff(a).] HEW has implemented this requirement by elaborate regulations. [20 C.F.R. 405.701 *et seq.*] If HEW determines to reject payment, in whole or in part and for any reason, including the lack of medical necessity, it must entertain a protest from the patient, not the hospital, and it must afford that patient an adversary administrative hearing which is subject to judicial review, provided that certain minimum dollar amounts are satisfied. The review rights are important to the patient who remains obligated to the hospital. On the other hand, the hospital is not a party to such proceedings because the determination does not affect the hospital's right to payment; it is entitled to payment from either the patient or Medicare.[17] However, this statutory framework, for case-by-case prepayment review of medical necessity and all other

[16] Retroactive determinations and recoupment also would result in unlawful denials of benefits under the days of coverage limitation, since days retroactively determined not to be covered were counted as covered, at the time, in applying the spell-of-illness limitation. [42 U.S.C. 1395d]

[17] A memorandum from the Bureau of Health Insurance to the Office of General Counsel/SSA dated December 18, 1975 states—"[T]here is no requirement for an adversary type hearing in the law or regulations (or in our claims processing procedures) for providers adversely affected by § 1862(a)(1)—[42 U.S.C. 1395y(a)(1)]—denials except for those appeals available to beneficiaries on a bill by bill basis through BHA."

conditions to payment, is entirely circumvented when HEW attempts to recoup retroactively from the hospital, since HEW denies that the requirements of 42 U.S.C. 1395ff and 20 C.F.R. 405.701 *et seq* (promulgated thereunder) are available to a provider.[18] One may well ask why Congress would, on the one hand, have *expressly* provided for an elaborate procedure for contesting medical necessity *vis-a-vis* the patient on a case-by-case while, at the same time, *impliedly* giving HEW the incompatible power totally to negate that approach by paying first and recouping later from the hospital. The answer must be that Congress would not have done so.[19]

The decision below, therefore, sanctions an approach and a result which are both different from and inconsistent with the administrative framework established by the Act. And because the hospital may have neither legal nor practical recourse against the patient for reimbursement, the decision below erroneously transforms the hospital into the insurer, penalizing the hospital with staggering liability because, with no prior notice or warning, it did no more than follow the instructions of the patient's attending physician.

The decision to imply such a recoupment power against a hospital, exercisable at any time, in per-

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[18] But see 42 U.S.C. 1395pp. added in the 1972 amendments. HEW has not relied upon, or proceeded under § 1395pp in the present case.

[19] In *T.I.M.E., Inc.* v. *United States*, 359 U.S. 464 (1959) and *United States* v. *Associated Transport, Inc.*, 505 F.2d 366 (D.C. Cir. 1974), this Court and the Court of Appeals for the District of Columbia, respectively, held that the existence of statutory procedures precluded the Government from resorting to common law procedures which were incompatible with the statute.

petuity, could only have been based on the highly simplistic assumption that Congress intended to elevate the preservation of Federal funds above all other considerations in the administration of the Medicare program; but this assumption is contrary to the broad remedial purposes of the Act. Cf. *Sowell* v. *Richardson,* 319 F.Supp. 689, 691 (D.S.C. 1970). As noted above, the Act expressly requires the payment of hospital services, during a grace period after actual notice, even when hospitalization is unnecessary; and both the Congress and the Courts have recognized that the paramount interest under the Act is not perfect efficiency but instead is to make medical services available to a certain segment of society,[20] based on the medical judgment of the patient's physician,[21] without interference in the providing of medical treatment,[22] and without deterring hospitals from providing the best of modern care.[23]

Instead of making the financial interests of the federal fund of superior importance to all other considerations, Congress attempted to accomplish a delicate balancing of competing interests in what was then a most controversial program; the prepayment review procedures of 42 U.S.C. 1395ff reflect that attempt. As far as the patient and hospital are concerned, a current review on a case-by-case basis might result in HEW not paying a portion of the hospital bill.[24] However,

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[20] *Hultzman* v. *Weinberger*, 495 F.2d 1276 (3rd Cir. 1974); *Sowell* v. *Richardson, supra.*

[21] 1965 U.S. Cong. & Adm. News 1986; 42 U.S.C. 1395f(a)(3).

[22] 42 U.S.C. 1395.

[23] 1965 U.S. Cong. & Adm. News 1967-1968.

[24] The data recently supplied by HEW to Mt. Sinai indicates that HEW has refused payment on grounds of lack of medical necessity as well as on other bases.

a current rejection identifies the patient and gives the hospital the opportunity to recover from the patient who, in turn, may contest coverage with HEW as noted *supra*. Even if the hospital cannot recover from the patient because of the patient's inability to pay, the loss is relatively small and the incident permits the hospital, physician and HEW to focus upon a current practice, engage in mutual education and either moot the dispute or avoid a recurrence.[25] It permits treating the issue when the facts are fresh and witnesses and evidence are available, and it lets a hospital rely on such determinations without proceeding under the ever present and ominous threat of a potentially catastrophic liability.

By contrast, retroactive recoupment eliminates reliance, creates uncertainty and an inordinate financial risk, nullifies the statutory grace period, raises the issues long after they have become stale and either impedes or precludes the hospital from seeking payment from the patient, all without any of the educational benefits of the prepayment review approach. There is, therefore, a vast difference between reviewing medical necessity on a current case-by-case basis and reviewing it on a retroactive basis, and this difference is of vital significance in this case. Congress provided for only the former and hence, notwithstanding HEW's monetary-based arguments, it is unreasonable to conclude that Congress intended to approve practices outside the Act that would undercut the very procedures it enacted, destroy the balance it sought to achieve and create the devastating and unfair burden on hospitals which the decision below contemplates.

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[25] Compare 42 U.S.C. 1395h(b)(1)(B).

In addition to the above, there is a basic flaw in the decision below which, ironically, even the Court of Appeals admitted when it acknowledged that it was creating an anomaly or inconsistency in the Act. As noted, the patient is obligated to bear the cost of his hospital bill if, after a Sec. 1395ff proceeding, HEW's refusal to pay is upheld. The Court below recognized that an implied common law recoupment right conflicted with the Act if it meant that, after HEW's recoupment from the hospital, the hospital could then recover from the patient, since this would result in the patient being held liable without the benefit of Sec. 1395ff procedures which, of course, the hospital could not grant; the Court noted that this was a severe anomaly.[26] In its opinion on Mt. Sinai's request for rehearing, the Court below suggested that this anomaly might be resolved if the hospital had no right to seek reimbursement from the patient, thereby resulting in inconsistent coverage determinations—*i.e.*, that HEW may view a particular service as necessary for purposes of establishing the rights of the patient, but as unnecessary for purposes of claiming recoupment from the provider.[27] Not even HEW has contended that such an inconsistency is proper under the Act. Nor has HEW disputed that, under the Act, the patient is liable to the hospital for services not covered by Medicare.[28] To imply a power that creates admitted anomalies or inconsistencies under the Act must be erroneous.

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[26] Opinion, fn. 17 [App. 14a]. Cf. Opinion denying rehearing [App. 27a].

[27] Opinion denying Rehearing [App. 27a].

[28] HEW's Opening Brief below, p. 27.

The Court below, however, based its decision on subsection (b) of 42 U.S.C. 1395gg (as originally enacted) which states no more than that HEW may recover, from a patient, the excess paid "over the correct amount," if the excess cannot be recouped from the provider. While acknowledging that this section does not itself authorize recoupment from a hospital or state when or how it may be done, the Court concluded that the section impliedly assumed a common law right of recoupment against a hospital where HEW retroactively decided it had paid for medically unnecessary services.

In light of what has been said above, the Court's jump to this conclusion was both unnecessary and wrong. The oblique reference in 42 U.S.C. 1395gg (as it was before the 1972 amendments) is no more than a receptacle to pick up claims provided elsewhere, independent of the Medicare Act (to be read in *pari materia*), such as claims which HEW may have for fraud or false statements on the part of the hospital. See *e.g.*, *Peterson* v. *Weinberger*, 508 F.2d 45 (5th Cir. 1975). To the extent that the Court below believed that 42 U.S.C. 1395gg incorporates (but does not create) claims that HEW may have against a hospital *under* the Act as opposed to claims arising from *independent* bases, its ultimate conclusion fails to consider the relationship of 1395gg to the rest of the Act. While the Act does not expressly authorize adjustments against a provider based on retroactive coverage determinations (as both Courts below recognized), it does provide for retroactive (*i.e.*, post-payment) adjustments based on final determinations of the *cost* of services. [42 U.S.C. 1395g.] Thus, where an amount in excess of the correct amount—*i.e.*, the cost—of a service has been

paid, there is a right to recovery from the provider, and Sec. 1395gg requires that that route be pursued first.[29] But where the issue is medical necessity (coverage), no right against the provider exists.

In view of (1) the express pronouncements to the contrary, (2) the erroneous conclusion by HEW as to the source of its alleged power, (3) the inconsistent statements by the Justice Department as to what the law provides, (4) the general purposes and balancing structure of the Act, (5) the devastating result, (6) the notice and three-day grace period provisions, (7) the prepayment review procedures of Sec. 1395ff, and (8) the anomalies and inconsistencies that flow from the decision below, the decision is clearly erroneous to the extent it permits recoupment from a hospital based on medical necessity (as opposed to cost) determinations. If the Fifth Circuit's decision is allowed to stand, the administrative framework enacted by Congress will be emasculated and replaced by an unauthorized administrative framework that denies hospitals their rights under the Medicare Act.

2. Even if common law recoupment were implied in the Medicare Act generally, it would be inapplicable here.

Even if the Court of Appeals was correct in implying a common law recoupment right, its decision is contrary to that right as the Court itself defined it. Relying on *United States* v. *Barlow*, 132 U.S. 271, 280, fn. 10 (1889), the Court below expressly noted that HEW would have no common law right of recoupment (even if in principle that right were available in the context

[29] Note that 42 U.S.C. 1395gg(a) states that any payment to a provider on behalf of an individual is regarded as a payment to such individual.

of the Medicare Act) if the payments, which it sought to recover, had been made because of an error in judgment.[30] Yet, in the case at bar, the sole basis for recoupment is alleged error in judgment as to whether a particular treatment should have been considered medically necessary. The legislative history of the Medicare Act, HEW regulations, and judicial decisions all recognize that the determination of medical necessity is judgmental, and that the attending physician is in the best position to make that judgment. See, *e.g., Hultzman* v. *Weinberger,* 495 F.2d 1276 (3rd Cir. 1974) and 20 C.F.R. 405.1035(g) cited therein; S.Rep. No. 92-1230, 92d Cong., 2d Sess. 295 (1972); and Fifth Circuit Opinion [App. 1a]. This is not a case where a hospital has mistakenly received payment for a service not rendered or where there has been a mistake in identifying the services. This is simply a case of whether HEW may recoup funds previously paid as the result of an alleged error in subjective medical judgment, and hence common law recoupment is inapplicable for that reason alone. Additionally, Mt. Sinai has not been unjustly enriched, having received no more than it was unquestionably entitled to—i.e., the cost of services actually rendered. Finally, recoupment from the hospital is barred by 42 U.S.C. 1395gg (a), under which the hospital is not to be deemed the recipient of the payment sought to be recouped.

3. The decision below violates Mt. Sinai's Fifth Amendment rights.

The hospital's right to payment for services rendered is a property right protected by the Fifth Amendment, yet the decision below would result in a

[30] *Cf. Springdale Convalescent Center* v. *Mathews,* — F.Supp. —, CCH Med. & Med. Guide ¶ 27,559 (N.D. Ga., Sept. 29, 1975).

confiscation of that right. Even if Mt. Sinai has the theoretical legal right to recover from the patients, notwithstanding 42 U.S.C. 1395ff and likely limitations defenses, it would be unable to do so by virtue of HEW's use of an anonymous statistical approach where a part of every patient's services are deemed unnecessary; it is difficult to believe that a patient could, in turn, be held liable to reimburse the hospital as a result of the HEW statistical analysis. Hence, whether the hospital is precluded from its admitted right of recovery because of legal or practical reasons, the net effect of the decision below is to deprive the hospital of property which unquestionably was due it, whether from the patient or HEW, and this deprivation will occur without benefit of time limitation, procedural protection or express statutory authorization. Such a deprivation violates Mt. Sinai's Fifth Amendment rights. *Cf. Springdale Convalescent Center* v. *Mathews, supra; South Windsor Convalescent Home* v. *Weinberger,* — F.Supp. —, CCH Med. & Med. Guide ¶ 24,474 (D. Conn., July 17, 1975).

Moreover, if Congress had impliedly given HEW the perpetual right to recoup, without giving the hospital any procedural or time protections, the chilling effect of the ever present threat created thereby would not only have impacted enough on the practice of medicine so as to violate 42 U.S.C. 1395, but the impact would have been akin to the mandatory influence found to be unconstitutional in *Doe* v. *Bolton,* 410 U.S. 179 (1973) and *Roe* v. *Wade,* 410 U.S. 113 (1973). See also *American Medical Association* v. *Weinberger,* — F.2d — (7th Cir. 1975) (stating that the implementation of a prospective review of medical necessity, although a facially constitutional requirement under the

1972 amendments might be unconstitutional, depending upon the impact it had on the practice of medicine).

The facial constitutionally of the 1972 amendments, to the extent they created a new procedure for current review of medical necessity, was recently upheld by a three judge Court in *Association of American Physicians and Surgeons* v. *Weinberger,* 395 F. Supp. 125 (N.D. Ill. 1975), *aff'd per curiam,* — U.S. —, 44 U.S.L.W. 3295 (November 18, 1975). The basis of that decision was, in part, that the new law contained provisions satisfying procedural due process requirements (notice, hearing and judicial review), did not involve a private insurance company intermediary (which might have a bias or conflicting interest) in the final decision, and did not have an undue impact on the practice of medicine. If such statutory protections are necessary to uphold the facial constitutionality of a prospective case-by-case review approach, then *a fortiori* they should be prerequisites for the validity of a far more onerous retroactive recoupment approach. Since, in the instant case, there are none of these statutory safeguards, the Fifth Circuit's interpretation is constitutionally infirm.

CONCLUSION

The statutory and constitutional issues herein presented have sufficient national importance so as to warrant this Court's review of the erroneous decision below. For the reasons stated, a writ of certiorari should be issued to the Court of Appeals for the Fifth Circuit to review that decision.

Respectfully submitted,

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APPENDIX

Court of Appeals Opinion

APPENDIX

UNITED STATES COURT OF APPEALS,
FIFTH CIRCUIT.

No. 74-2154.

MOUNT SINAI HOSPITAL OF GREATER MIAMI, INC.,
Plaintiff-Appellee,

v.

CASPAR WEINBERGER, Secretary of Health, Education and Welfare, and Blue Cross of Florida, Inc., *Defendants-Appellants.*

Aug. 8, 1975.

* * *

Appeal from the United States District Court
for the Southern District of Florida.

Before BROWN, Chief Judge, and GODBOLD and CLARK, Circuit Judges.

GODBOLD, Circuit Judge:

This case arises from an attempt by the Department of Health, Education and Welfare [HEW] to recoup $6.3 million from Mount Sinai Medical Center ["the hospital"]. This amount was allegedly paid to Mount Sinai for medically unnecessary services and hospital stays provided to beneficiaries under the Medicare hospital insurance system from 1966 to 1971. Before HEW could commence recoupment by putting into effect a partial freeze on future payments to Mount Sinai to offset the amount claimed, the hospital sued for temporary and permanent injunctive relief against the freeze.

HEW's attempt to recoup the funds was based on its theory that the government has a common law right to recoup monies paid out illegally. The District Court

granted temporary relief. Later, after hearing and on cross motions for summary judgment, it accepted Mount Sinai's principal defense that the complex statutory and administrative scheme governing the Medicare program had abrogated the government's right to recoup, and it granted a permanent injunction. 376 F.Supp. 1099 (S.D. Fla., 1974). HEW appeals. We reverse on the recoupment issue and remand for further proceedings.[1]

Mount Sinai is a major provider of services under the Medicare program, the largest in the southeast and, measured in terms of cost of services, more than twice as large as the second largest provider in its state. From 60 to 70 percent of Mount Sainai's patient-days and total billings are now attributable to Medicare.

Allegations of wrongdoing by Mount Sinai in operation of the Medicare program were made in 1972. HEW subjected to review by a peer review committee of doctors a sample consisting of the charts of 710 patients from a single year. The statistical results of the committee's determinations of medically unnecessary hospital stays and ancillary services drawn from this sample were then applied to all years in question, producing a calculated, as opposed to actual, overpayment figure of $6.3 million.

I. The Medicare System

Federal Health Insurance for the Aged, popularly known as Medicare, was enacted by Congress in Title I of the Social Security Amendments of 1965, P.L. 89-97, §§ 101-122, 79 Stat. 286, July 30, 1965, as Subchapter XVIII of

[1] The parties have briefed and argued two substantial issues other than the recoupment question: whether HEW followed properly promulgated regulations in attempting to institute the freeze, and whether in any event the procedures utilized comported with Mount Sinai's Fifth Amendment due process rights. We do not reach these issues, which are for the District Court to rule on in the first instance.

the Social Security Act, codified as 42 U.S.C. §§ 1395-1395*ll* (1970), as amended 42 U.S.C. §§ 1395-1395pp (Supp. III).[2] The system contains two substantively distinct parts, one providing insurance for hospital and related post-hospital services, known as Part A, 42 U.S.C. §§ 1395c-1395i-2 (Supp. III), the other providing insurance for supplementary medical services, primarily physicians' services, known as Part B, 42 U.S.C. §§ 1395j-1395w (Supp. III). This case concerns Part A.[3]

Under Part A, the hospital insurance program, persons aged 65 and older, § 1395c,[4] receive essential hospital services, § 1395d, paid for from a trust fund financed by wage taxes on employees and self-employers, 26 U.S.C. §§ 1401 (b), 3101(b) and 3111(b) (1970), the Federal Hospital Insurance Trust Fund, § 1395i. The hospital services are paid for directly by the government. However, only those hospitals and other institutions that qualify as "providers of services" under § 1395x(u),[5] incorporating § 1395x(e), (j), and (*o*), and that are accredited under § 1395bb, are eligible to receive payments under the program, § 1395f(a). They can do so only after entering into agreements with the Secretary of HEW meeting the requirements of § 1395 cc(a), § 1395f(a). They must agree, among other things, not to charge a Medicare beneficiary for any services re-

[2] And miscellaneous other sections of Title 42 not pertinent here.

[3] Part B is the subject of a companion case, Szekely v. Florida Medical Association (Weinberger), also decided today, *see* — F.2d —, —. Part C, 42 U.S.C. §§ 1395x-1395pp (Supp. III), containing general provisions applicable to both Parts A and B, is at issue in both cases.

[4] All references to sections mean sections of Title 42 of the U.S. Code, 1970 edition, or any supplement thereto, unless indicated otherwise.

[5] The provision cited also refers to extended care facilities (changed to skilled nursing facilities by the 1972 amendments) and home health agencies.

ceived under the program, § 1395cc(a)(1)(A), other than for co-insurance and deductibles prvoided for in § 1395cc (a)(2)(A), but instead to look only to the government for compensation. Payment for services is based on the reasonable cost of such services, § 1395f(b), as determined pursuant to § 1395x(v) and the appropriate regulations, 20 C.F.R. § 405.401 *et seq.*

Day-by-day administration of the Medicare program is handled by "fiscal intermediaries." These are private, non-government entities, frequently health and accident insurance companies (including "Blue Cross" organizations) nominated by a provider or group of providers. They enter into contracts with HEW and serve as HEW's agent for many functions, such as hospital audits, information dissemination, and fund disbursement, § 1395h. Defendant Blue Cross of Florida, Inc., is the fiscal intermediary between Mount Sinai and HEW and also agent for HEW. Defendants Blue Cross and the Secretary of HEW will be referred to collectively as "HEW."

Providing services to a beneficiary raises two important and distinct issues: (1) whether the services provided are covered by § 1395d and not excluded by § 1395y; and (2) whether the amount paid for the services is the "reasonable cost" under § 1395x(v).[6] Each issue is resolved under distinct procedures. In resolving the question before us we must consider the bearing of these separate procedures on a recoupment section that makes no distinction between cost questions and coverage questions.

A. *Coverage determinations*

The issues in coverage determinations are defined by §§ 1395d and 1395y. Section 1395d defines the benefits covered by Medicare: in-patient hospital services, post-

[6] A third question, eligibility of the beneficiary under §§ 1395c and 1395d, is procedurally indistinguishable from the coverage determinations under §§ 1395y and 1395d, 1395ff(b)(1)(C).

hospital extended care services and post-hospital home health services with annual day or visit limits for each, § 1395d(a)(1)-(3). Section 1395y defines exclusions from the general definition of scope of benefits in § 1395d. The most important as a practical matter are the exclusions from coverage of services "which are not reasonable and necessary for the diagnosis or treatment of illness or injury . . . ," § 1395y(a)(1), or which are for "custodial care," § 1395y(a)(9). The instant case involves services found by HEW not to be covered because not medically necessary under § 1395y(a)(1).

The parties primarily concerned with coverage determinations are HEW and the beneficiary. In theory the provider's interest is slight because the coverage determination merely has the effect of resolving who shall pay it for the services, Medicare or the individual. The administrative procedures for making the coverage determination reflect these theoretical interests, for only the beneficiary has a right to hearing and judicial review under the statute, §§ 1395ff(b)(1)(C) and (b)(2), and the regulations, 20 C.F.R. §§ 405.701 *et seq.*, see particularly §§ 405.702, -.710, -.720, -.730 and -.750.[7] As a practical matter, however, the provider is greatly concerned about who its debtor is. The alternative debtors are the government and a private individual who may be hard to find, harder to collect from, and impossible to placate if collection from him is necessary.

B. *Cost determinations*

The issues in cost determinations are defined by § 1395x (v) and the regulations pursuant thereto, 20 C.F.R. § 405.-401 *et seq.* The rules for what constitutes reasonable cost have a substantial impact on when and how the reasonable cost determinations can be made. The general rule is that

[7] The 1972 amendments give the provided standing and a right to judicial review in coverage determinations. *See* footnote 22, *infra*.

Medicare will cover all costs of covered individuals, and no costs of individuals not covered, 20 C.F.R. §§ 405.454(a)(1) and (b)(1). The costs of a hospital department or service allocable to Medicare beneficiaries is based on the proportion of charges made with respect to Medicare beneficiaries to all charges for hospital services, 20 C.F.R. §§ 405.452 (a), (b) and (e)(1). This computation of the proportion of charges can be made only at the end of some fiscal period. Thus, the final determination of the reasonable costs for any given service can be finally determined only at the end of the fiscal year during which the service was supplied. HEW is required to make periodic interim payments in the meantime, not less frequently than monthly, § 1395g, to meet hospitals' liquidity needs, 20 C.F.R. § 405.402(b)(1). These payments are approximations of what HEW and the hospital expect will be properly chargeable to Medicare. The fiscal intermediary audits the accounts of each hospital on an annual basis to determine how much the hospital should have been paid. Subsequent payments for the following year's services are adjusted to compensate for prior payments that were above or below the amounts actually owed, § 1395g and 20 C.F.R. §§ 405.-451(b)(1) and 405.454(a) and (f).

Section 1395g is limited in its impact to cost redeterminations and does not touch coverage problems. Despite its general references to "overpayments," similar to § 1395gg (b), consideration of the Medicare Act as a whole shows that this section has much more limited scope than is contended for by the government. The District Court's opinion on this question correctly analyzes the statutory scheme. 376 F.Supp. at 1127-1129. Congress chose to pay providers only the "reasonable cost" of services, to be determined at the end of each fiscal year. Lump sum annual payments made long after services were rendered would be inadequate in light of hospitals' liquidity needs, so Congress authorized interim estimated payments to providers to be paid at least monthly with subsequent adjustments for overpayments and underpayments. Thus, some adjustment for overpayments and underpayments was necessitated by the "reasonable cost" payment system provided in §§ 1395f(b) and 1395x(v), and specifically by the proviso for "suitable corrective retroactive adjustments." § 1395x(v)(1)(A)(ii). This is exactly the function of the adjustments authorized in § 1395g. The contents of §§ 1395g and 1395x(v)(1)(A)(ii) track each other so closely that there would seem to be no other conclusion than that Congress intended that § 1395g relate only to cost determinations.

The parties primarily concerned with cost determinations are HEW and the provider. The beneficiary has no interest in them because the provider has already agreed to look only to HEW for compensation for services provided, § 1395cc (a)(1)(A).[8] The statute does not provide for any type of administrative hearing or judicial review for the provider itself, § 1395g, *cf.*, § 1395ff. And at the time the dispute leading to the litigation occurred no regulation provided any right to hearing or review. The regulation utilized by HEW and relied on by HEW in this litigation was promulgated pursuant to § 1395g. It authorizes HEW to suspend payments to a provider in whole or part when HEW determines that the provider has been overpaid, 20 C.F.R. § 405.370(a)(1), or has reliable information to that effect, 20 C.F.R. § 405.370(a)(2). This section provides for no "hearing" properly so called beyond a right to a statement from HEW of the reasons for the suspension and a privilege to submit information to show that the suspension should not be put into effect, 20 C.F.R. § 405.371(a), or would cause irreparable harm, 20 C.F.R. § 405.373(a). At least one district court has held the provider has a constitu-

[8] The beneficiary cannot be held liable where a provider has been paid more than its reasonable cost for services rendered to the beneficiary because the beneficiary cannot be at fault for the results of a proceeding in which he played no part, direct or otherwise, § 1395gg(c). *See* Part III. A, *infra*.

tional right to a hearing and judicial review on adverse reasonable cost determinations. *Coral Gables Convalescent Home, Inc.* v. *Richardson*, 340 F.Supp. 646 (S.D.Fla., 1972). HEW has issued regulations for such cost redetermination hearings, 20 C.F.R. §§ 405.490–405.499i (1973), now § 405.1801 *et seq.*

C. The adjustment and recoupment provision

The final element in the statutory scheme is § 1395gg, which authorizes HEW to recoup some overpayments from beneficiaries' old-age benefits, but only where "the excess over the correct amount cannot be recouped from [the] provider." The section does not by itself authorize recoupment from providers, but it establishes the failure to recoup from providers as a precondition to recoupment from beneficiaries, which it does explicitly authorize.[9] It thus assumes that there is some kind of right in HEW to recoup overpayments from providers, but it gives little hint as to the basis or scope of this right. It is not seriously disputed that this reference to recoupment means the common law recoupment for which the government contends in this case. But the question to be resolved is whether the scope of this common law right has been affected by the pervasive and complex statutory scheme present in the Medicare hospital insurance system.

II. The Government's Common Law Right to Recoup

The trial court held that the government's common law right to recoup would be available but for the statute present in this case. 376 F.Supp. at 1126. We agree. In

[9] Congress added a second precondition in the 1972 amendments to the Medicare Act: the provider must also be "without fault" before HEW can proceed against the beneficiary, §1395*gg* (b)(1)(B). In effect, this means that recoupment cannot be had from the provider where it was without fault. This was Congress' intent. *See* footnote 26, *infra*.

some circumstances when government funds are improperly paid out the government has a claim enforceable either by direct suit [10] or by setoff against money owed by the government to the recipient of the illegally dispensed funds.[11] The difficult question is what kinds of illegal or improper disbursements create this cause of action. Where the relevant statute did not authorize such payment, *United States* v. *Wurts*, *supra*, footnote 10, *Hilburn* v. *Butz*, *supra*, footnote 11, or specifically prohibited it, *United States* v. *Barlow*, *supra*, footnote 10, the United States has a cause of action to recover the money thus erroneously paid, and "no statute is necessary to authorize the United States to sue in such a case," *United States* v. *Bank of Metropolis*, 40 U.S. at 401, 10 L.Ed. at 783. Similarly, where the payments would be authorized but for erroneous understandings of fact, the government may recover, even where its own employees and agents were partly responsible for failing to discover the correct facts, *United States* v. *Barlow*, *supra*, footnote 10, but not where they were guilty of a "mere error of judgment," 132 U.S. at 280, 10 S.Ct. at 79, 33 L.Ed. at 351.[12]

Here, the statute specifically prohibits any payments for services that are medically unnecessary, § 1395(a)(1). This

[10] United States v. Wurts, 303 U.S. 414, 415, 58 S.Ct. 637, 638, 82 L.Ed. 932, 934 (1938); United States v. Barlow, 132 U.S. 271, 279-280, 281-282, 10 S.Ct. 77, 79-80, 33 L.Ed. 346, 351-352 (1889); Weiss v. United States, 296 F.2d 648 (CA 5, 1961).

[11] United States v. Munsey Trust Co., 332 U.S. 234, 67 S.Ct. 1599, 91 L.Ed. 2022 (1947); Hilburn v. Butz, 463 F.2d 1207 (CA 5, 1972); *see also* United States v. Bank of Metropolis, 40 U.S. (15 Pet.) 377, 400-401, 10 L.Ed. 774, 783 (1841), in which defendant in an assumpsit action by the United States was denied a setoff where the claimed credit on which it was based was not authorized.

[12] Although the Court there makes reference to a statute authorizing suit, quoted in 132 U.S. at 277, 10 S.Ct. at 79, 33 L.Ed. at 350, the distinction drawn between errors of judgment and mistakes of fact is not derived from the words of the statute.

prohibition is part of the statute creating the administrative system under which all payments are authorized; it implicitly limits the authority of HEW officials to make payments under Medicare. This is exactly the kind of limitation which under federal common law creates both a legal claim in the government and a remedy by way of set-off, as was attempted to be exercised by HEW in this instance.[13] Moreover, the government has asserted that its agents did not exercise their judgment on the precise question of medical necessity but acted on erroneous understandings of the facts presented to them in the certificates executed by the provider and doctors under § 1395f(a) and § 1395f(a)(3) in particular. See *United States* v. *Barlow*, *supra*, footnote 10, and compare *Dana Corp.* v. *United States*, 470 F.2d 1032 (Ct.Cl., 1972).

In finding the government's common law recoupment right applicable but for the statutory scheme present here the trial court drew no distinction between gratuitous payments made to beneficiaries and payments to contractors or others where some legal consideration might have passed. This is in accord with the case law. The issue is not the nature of the relationship or the position of the recipient but whether the money was illegally or erroneously paid. The government has previously prevailed in recouping funds paid to government contractors and others who were not gratuitous beneficiaries. *United States* v. *Bank of Metropolis*, *supra*, footnote 11. *Wilson Clinic & Hosp., Inc.* v. *Blue Cross of So. Carolina*, 494 F.2d 50, 52 (CA4, 1974); *United States* v. *Mead*, 426 F.2d 118, 124 (CA9, 1970); *Dana Corp.* v. *United States*, *supra*; *Cf.*, *Weiss* v. *United States* *supra*, footnote 10, *Hilburn* v. *Butz*, *supra*, footnote 11

Moreover Mount Sinai is not a neutral, innocent third party in this three-way transaction between HEW, Medi-

[13] *Cf.* United States v. Associated Transport, 505 F.2d 366 (CA DC, 1974).

care beneficiary, and Medicare provider. The decision to provide a service is made by the individual attending physician, who is far better informed on both the medical issue and the scope of Medicare coverage than is the patient-beneficiary. The physician is either an employee of the hospital or a doctor with staff privileges. Whatever else the granting of staff privileges may connote, it is clear to us that it involves a delegation by the hospital of authority to make decisions on utilization of its facilities. Certainly in the case of Mount Sinai, where the majority of patients and patient-days are under Medicare insurance, this must also include a delegation of authority to permit the use of its facilities for Medicare-financed patients.

It is suggested by Mount Sinai that recoupment should not apply where it has not received a "windfall." The hospital did not receive money without giving something in return. No one questions that services were provided at reasonable cost for all the payments actually received. But the unfairness in not paying for services that were provided has nothing to do with recoupment. Indeed, this provision of services without payment by Medicare is exactly what happens no matter when HEW decides a service is not covered. Mount Sinai does not challenge the authority of the government to make its decision not to pay for a service after the performance of the service. The only distinctions between not making payment in response to an original claim, which Mount Sinai concedes is proper, and seeking to recoup payment after it has been made, which the hosptial challenges, are the making of the preliminary decision to pay and the subsequent passage of time. Whether payment is denied or payment is made and recoupment asserted, the hospital has already provided the services and suffers the same loss of compensation from the Medicare program for services rendered. In both situations, it must then turn to the patient for payment. The delay incident to the use of recoupment

may cause greater difficultly in proving that the services given were medically necessary and in collecting from the patient. But we do not consider these factors to have any bearing on the government's right to recoup.

III. Effect of the Statute on the Right to Recoup

The trial court held that the right to recoup was abrogated in this case by the comprehensive "all-encompassing" administrative system embodied in the Medicare Act and its amendments, 376 F.Sup. at 1127. The court found congressional intent to abrogate "manifested by the totality of the statutory scheme," *id.*, at 1130. We think that Congress' intent when it enacted the Medicare Act in 1965 was not to limit the common law right. Provisions not referred to by the trial court [14] show that Congress' understanding in 1972 when it amended the law was that the common law right was intact and was expected to be utilized. The recoupment right does not always fit consistently and logically into the statutory system, but the alternative of no right to recoup produces even more severe incongruities. Provisions aparently contrary to the government's right to recoup serve important functions that complement rather than displace or supersede the recoupment right. Where a difficult but not dispositive conflict appears between statute and common law, Congress has already acted in the 1972 amendments to reconcile the statute to the recoupment right.

A. Congressional intent—the original act

Section 1395gg justifies recovery of overpayments paid to providers from the beneficiaries who received the services paid for by saying that any payment to a provider "shall be regarded as a payment to" the beneficiary who

[14] And presumably not called to its attention since not cited to us by either of the parties until post oral argument memoranda were filed at our request.

received the services for which the payment was made, § 1395gg(a). It then authorizes HEW to deduct the amount owed from the beneficiary's old-age benefits under Title II of the Social Security Act, *but only when "the excess over the correct amount cannot be recouped from [the] provider . . .,"* § 1395gg(b)(1) (emphasis added).[15] On its face, this reference to recoupment from providers would appear to be dispositive. It shows that Congress expected and intended HEW to recoup improper payments to providers without limitation as to the reason for the overpayment, and authorized deductions from beneficiaries' old-age benefits only as a last resort after recoupment had failed. However, we must go deeper than the face of the provision.

The alternative remedies of recoupment and adjustment posit an area of comon liability where both provider and beneficiary are alternatively responsible to the trust fund for the same overpayment. Providers can be held liable for reasonable cost overpayments, and beneficiaries can be held liable for coverage overpayments. But to have common liability either providers must be subject to liability for coverage overpayments or beneficiaries must be subject to liability for reasonable cost overpayments.[16]

Elsewhere the act sets up different procedures for determinations respecting cost and those respecting coverage. Providers take no part in coverage hearings and beneficiaries have nothing to do with cost determinations. Mount Sinai puts great emphasis on this procedural system and suggests that it is out of keeping with this bifurcated

[15] This language now apepars as § 1395gg(b)(1)(A). A 1972 amendment added a second precondition to deduction from a beneficiary's old-age benefits: the provider must also be without fault for the overpayment, § 1395gg(b)(1)(B). *See* footnote 26, *infra*.

[16] Or both could be liable for coverage overpayments and both liable for cost overpayments. For reasons appearing below, we think not.

scheme to subject it to recoupment of funds overpaid with respect to coverage. This argument has little force because the common liability posited by the section must exist inconsistently with the procedural structure either for providers or for beneficiaries or for both, and the same argument made by Mount Sinai is available to a beneficiary.

A difficulty with subjecting providers to liability for non-covered services is that the provider then has an action over against the beneficiary under state law. As between HEW and the beneficiary, HEW could not collect directly from the beneficiary because it has already made a determination of coverage under § 1395ff(b) to which HEW and the beneficiary were the only parties. Thus the beneficiary may become liable to the provider for the services received, even though in the only prior contact with the Medicare program, the coverage determination under § 1395ff(b), the decision made was that Medicare would pay for the service and the patient was not liable.[17] [18]

[17] This anomaly is rendered more severe because of the differing parties in the various determination procedures and the different procedural rights given each. The beneficiary has a statutory right to a hearing and, where the dispute rises above certain dollar minimums, a statutory right to judicial review, § 1395f(b)(2). These rights are elaborated on in HEW regulations, 20 C.F.R. § 405.701 *et seq.* But the provider, against whom HEW may proceed after its rights against the beneficiary have long lapsed, has no such protections. The hearings which the provider receives consists of a right to submit evidence on the issues of propriety of suspension and irreparable harm and the right to be apprised of the reasons for the suspension. See Part I. B, *supra*. Thus the administrative system's different procedures increase the probability of inconsistent results between different parties.

[18] Mount Sinai also suggests that subjecting it to coverage recoupment is unfair because of the limitation of § 3995ee(a)(1)(A) that providers agree not to charge beneficiaries for any covered services. This provision merely requires the provider to choose between charging the Medicare trust fund or charging the beneficiary for the service provided, depending on whether the service was covered or not. It does not prohibit the provider from charging the beneficiary for a non-covered service nor does it expose the provider to the sanctions of § 1395ee(b)(2)(A) for charging beneficiaries for covered services, so long as the provided thought the service was not covered and did not attempt to collect from Medicare for it. Mount Sinai may be concerned about the prospect of doctors deciding in favor of coverage only to be contradicted by the hospital's review or claims unit. The Act does not distinguish between doctors and providers in that way; they are viewed as a single entity. Once they have resolved their differences they can act, and they can charge whoever should be liable, Medicare if the service was covered, the beneficiary if it was not covered.

A difficulty with subjecting beneficiaries to liability for payments in excess of reasonable cost is that the beneficiary is truly an innocent third party. He not only did not take part in the original reasonable cost determination, but he can neither gain nor lose by the outcome and can have no responsibility for erors. No matter what the outcome of this determination, the beneficiary can suffer no additional liability. He has no knowledge of the determination and no real interest in the matter. Thus, the failure of Congress to have beneficiaries take part in reasonable cost determinations reflects beneficiaries' bona fide interests. In light of the unfairness in subjecting beneficiaries to this liability we do not think Congress intended such a result.[19]

To explain the common liability posited by § 1395gg while excluding provider liability for coverage overpayments, Mount Sinai contends that beneficiaries are subject

[19] By contrast, providers are not strangers to the coverage determination. It is the provider who makes a decision on coverage in the first instance and certifies to the medical necessity of the services provided. And who will be the provider's debtor liable for the services rendered will be determined in the coverage hearing. Thus, providers have both knowledge of and an interest in the hearing, and subjecting them to liability for coverage errors not only does not offend notions of fairness, but may be both fair and reasonable.

to liability for reasonable cost overpayments. This result it supposes is authorized by the basic premise of § 1395gg contained in § 1395gg(a), the subsection which says payments to providers are to be regarded as payments to the beneficiaries who received the services. Mount Sinai argues that Congress was simply recognizing beneficiaries as the ultimate recipients of the funds and placing on them the ultimate responsibility for incorrect payments.

We think Congress had something else in mind in enacting § 1395gg, and § 1395gg(a) in particular. No recovery against the individual beneficiary—who received only medical services, not payments from the trust fund—would ever be proper without some statutory authorization. That is the limited function of § 1395gg(a). Congress could not authorize reductions of old-age benefits without some reason, and the reason statutorily supplied is that Medicare payments are to be considered payments actually made to the beneficiary.

Thus, § 1395gg taken as a whole does not provide for primary responsibility of the beneficiary with narrow provider responsibility for payments in excess of reasonable cost. Rather, it posits general provider responsibility based on the fact that providers receive the funds, but permits a narrow category of recovery from beneficiaries, *i. e.*, when the provider is not available and the beneficiary was at fault for the erroneous payment.

Other parts of §1395gg suggest that Congress never intended beneficiaries to be held liable for administrative errors in cost determinations, errors which they had no part of, could not have contributed to if they wanted to, and in which they had no interest. Section 1395gg(c) prohibits recovery from the beneficiary by adjustment of old-age benefits where the beneficiary was without fault. A beneficiary cannot be at fault for erroneous cost determinations since he plays no role at all in the proceedings.

In light of this limitation of § 1395gg(c), we conclude that § 1395gg(b) was not intended to authorize recovery of overpayments based on erroneous reasonable cost determinations.

This leaves only responsibility for coverage errors as the common liability of provider and beneficiary. Thus coverage errors comprise the entire scope of operation of § 1395gg(b). The proviso in § 1395(b)(1)(A) requiring an attempt to recoup from the provider as a precondition to adjustment thus must contemplate provider liability for such overpayments.[20]

There is a possibility of inconsistent results in the different coverage determinations made between HEW and the beneficiary before payment and between HEW and the provider after payment, but this possibility is consonant with both the Medicare Act and general recoupment law. Standing alone, it does not show that Congress intended abrogation of recoupment. Congress was parsimonious in granting rights to providers in the original act. For example, where the provider's claim to a right to a hearing and judicial review was stronger—following adverse reasonable cost determinations under § 1395ff(b)(1)—Congress was silent and gave no statutory hearing or review.[21] Moreover, as to intent, Congress' response on learning of this difficulty was not to eliminate recoupment but to give providers standing in the administrative determination of coverage questions and the right to judicial review, § 1395-

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[20] This is not to say that recoupment is limited to overpayments due to coverage errors, but merely that it must include coverage errors.

[21] A district court has held that there is a constitutional right to a hearing and judicial review from such adverse cost redeterminations. Coral Gables Convalescent Home, Inc. v. Richardson, 340 F.Supp. 646 (S.D.Fla., 1972).

pp, added in 1972.[22] Nor does the possibility of inconsistent results require a holding of abrogation of common law recoupment on the basis that it is incompatible with the statutory system. The ultimate result of inconsistent decisions is that the provider must bear the loss. The fact that but for the earlier proceeding the provider might have been able to recover over from a third party, the beneficiary puts the provider in no worse situation than other recipients of improperly disbursed government funds. See the discussion of the recoupment right generally, Part II, *supra*.

B. *Congressional intent—the 1972 amendments*

Nothing in the orginal act explicitly referred to recoupment from providers of payments made for non-covered services. The 1972 amendments filled the gap. Four related amendments refine the defenses to recoupment for both beneficiary and provider and esablish that recoupment

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[22] The principal function of the new section is to authorize payments where neither provider nor beneficiary knew or should have known that a service was not medically necessary, § 1395pp(a), a modification of the exclusion in § 1395y(a)(1). The hearings for providers as well as beneficiaries is provided for in § 1395pp(d). Although not specified in terms, the most reasonable construction would be that where § 1495pp(a) authorizes payment (*i.e.*, the provider should not have known that the service was medically unnecessary), then § 1395gg(b) does not authorize recoupment (the provided was "without fault"). Conversely, where § 1395pp (a) does not authorize payment (*i.e.*, the provider should have known the service was medically unnecessary), then § 1395gg(b) does authorize recoupment (the provider was not "without fault"). Thus, authorization and recoupment interlock neatly and the hearing on authorization deals with the issues involved in recoupment. The § 1395pp(d) hearing may be held whenever authorization of payments is questioned, and that may occur either before or after payment, *viz.*, in a recoupment proceeding.

from the provider for payments for non-covered services is assumed.[23]

In reporting these amendments, the Senate Finance Committee told Congress:

> Under present law, the Secretary [of HEW] is required to recover overpayments made to or on behalf of an individual where it is determined that [the] services. . . were not covered under [M]edicare. Further, present law provides that overpayments made to providers or other persons for services furnished . . . which cannot be recovered from the overpaid provider[24] . . . may be recovered [by adjustment of the individual beneficiary's old-age benefits].

S.Rept. 92-1230, 92d Cong., 2d Sess., pp. 313-314 (1972).

The Senate committee assumed that providers could be held liable for payments for non-covered services. Acting on that assumption, it proceeded to recommend (and Congress subsequently enacted) refinements in §§ 1395gg(b) and (c). The refinement to HEW's right to make adjustments to a beneficiary's old-age benefits to recover overpayments is in effect a three-year statute of limitation.[25] The

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[23] The amendments are all contained in § 281 of the Social Security Amendments of 1972, Act of Oct. 30, 1972, P.L. 92-603, 86 Stat. 1454. Three of the amendments are discussed here. The fourth concerns Part B and is discussed in *Szekely, supra*.

[24] Strict reliance on the punctuation in the original Senate report of the phrase beginning "which cannot . . ." may lead to an interpretation contrary to that suggested by a reading of this portion of the legislative history as a whole. The ease with which errors of pnctuation can be made and overlooked makes us feel far more comfortable following the sense of the legislative history generally.

[25] Prior to 1972, adjustment of a beneficiary's old-age benefits to recover improper Medicare payments was permitted where the beneficiary was at fault and where such recovery by adjustment

refinement to HEW's right to recoup from providers makes non-fault a defense and sets up a presumption of non-fault three years after payment is made.[26]

Congress saw another problem: a provider required to make repayments might still attempt to collect from the beneficiary even though HEW itself was barred from doing so by the amendment to § 1395gg(c). The Senate report said:

> The amendment also requires that providers under their participation agreements (or physicians or other

was "not against equity and good conscience," § 1395gg(c). The 1972 amendment established the rule that adjustment was against equity and good conscience if the redetermination that services were not covered is made more than three years after payment, § 1395gg(c) [last sentence].

[26] Prior to 1972 it was not a valid defense to recoupment that a provider was not at fault for the overpayment. The amendment made absence of fault a defense, § 1395gg(b)(1)(B), and added the rebuttable presumption that the provider was not at fault where the redetermination was made more than three years after the original payment, § 1395gg(b) [last sentence].

Read narrowly, this change only says that a finding of the provider's non-fault is a precondition to adjustment of the beneficiary's old-age benefits to recoup the erroneous payment. Thus, it means that where the provider was at fault such adjustment is not permitted; where the provider was not at fault, adjustment is authorized. But adjustment is not required and recoupment is not prohibited. Conceivably, HEW might still have recoupment against the provider available as an alternate remedy. In light of the other restrictions on these old-age benefit adjustments, *e.g.*, § 1395gg(c), such an alternative would be reasonable. But the legislative history suggests otherwise. Congress added § 1395gg(b)(1)(B) to give providers protection similar to that for beneficiaries in § 1395gg(c) that "recovery . . . will not be made with respect to an individual who is without fault . . ." S.Rep. 92-1230, 92d Cong., 2d Sess., p. 314. Congress also added the last sentence to § 1395gg(b) giving providers presumption of non-fault after three years, analogous (but not identical) to the last sentence added to § 1395gg(c) giving beneficiaries an irrebutable rule of immunity.

> persons where they have accepted assignments) where collection of an overpayment is made from the provider or others, be prohibited, after 3 years, from charging beneficiaries for services found by the Secretary to be medically unnecessary or custodial in nature, in the absence of fault on the part of the individual who received the services.

S.Rept. 92-1230, 92d Cong., 2d Sess., p. 314 (1972). This amendment appears as § 1395cc(a)(1)(B).[27] By reason of this amendment providers are prohibited from charging patients for services not covered by Medicare where the determination of non-coverage is made more than three years after the original payment. This kind of protection would not be necessary unless (1) providers could be required to reimburse HEW for money received in payment for non-covered services, and (2) the determination of non-coverage could be made after the original determination under §§ 1395ff(a) and (b), indeed, more than three years after that determination.

Subsequent statements of Congress about what it meant years earlier in enacting a law are "entitled to great weight in statutory construction." *Red Lion Broadcasting* v. *F.C.C.*, 395 U.S. 367, 380-381, 89 S.Ct. 1794, 1801, 23 L.Ed.2d 371, 383 (1969). Here we have Congress at its most authoritative, adding complex and sophisticated amendments to an already complex and sophisticated act. Congress is not merely expressing an opinion on a matter which may come before a court but is acting on what it understands its own prior acts to mean. See *Red Lion, supra*, and cases cited in footnote 8, 395 U.S. at 380, 89 S.Ct. at 1801, 23 L.Ed.2d at 383. Moreover, certain of these new provisions explicitly refer to provider liability, whose existence is the question here litigated. To hold that HEW does not have the re-

[27] And § 1395u(b)(3)(B)(ii), with regard to physicians taking assignments under Part B. *See Szekely, supra.*

coupment power attempted to be exercised against Mount Sinai and giving rise to this case would render these amendments pointless and ineffectual.

The situation before is unlike those where Congress has attempted to direct subsequent court decisions on legislation whose original meaning was ambiguous, such as a Committee of Congress attempting to advise the courts of what it thought a prior Congress meant, *Bobsee Corp.* v. *United States,* 411 F.2d 231, 237, footnote 18 (CA.5, 1969); or Congress attempting to enact a clarifying amendment only to be rebuffed by the President who signed the original and thinks it has a different meaning, *Waterman S.S. Corp.* v. *United States,* 381 U.S. 252, 268-269, 85 S.Ct. 1389, 1398-1399, 14 L.Ed.2d 370, 379-380 (1963); of Congress failing to enact a clarifying amendment, from which ambiguous failure to act we are asked to draw some meaning, *United States* v. *Price,* 361 U.S. 304, 311-312, 80 S.Ct. 326, 330-331, 4 L.Ed.2d 334, 339-340 (1960); or legislative history vaguely referring to the prior state of the law, *United States* v. *Price,* 361 U.S. at 312-313, 80 S.Ct. at 331-332, 4 L.Ed.2d at 340.

Under these circumstances and in light of the construction we put on § 1395gg(b) as it existed prior to amendment, we think it clear that recoupment has always been available to HEW under facts like those of the instant case.

In an attempt to explain away these amendments particularly § 1395cc(a)(1)(B), Mount Sinai insists that they are merely refinements or limitations on a new liability, purportedly contained in § 1320c-9(b)(3), rather than on the pre-existing recoupment right. This argument verges on the frivolous. Section 1320c-9(b)(3) is part of the new system of professional standards review organizations (PSRO). The PSRO system was adopted to deal with "abuse" of the Medicare system by providers and physi-

cians.[28] The fine in § 1320c-9(b)(3) is merely an alternative sanction to total exclusion from the Medicare program, § 1320c-9(b)(1). To read this fine as the recoupment referred to in §§ 1395cc(a)(1)(B) and 1395gg(b) and (c) would produce gaping incongruities. The fine is levied only against Medicare abusers who "demonstrated an unwillingness or a lack of ability substantially to comply with" the obligation not to provide unnecessary or harmful services under § 1320-9(a)(1). Both of these grounds clearly envision some kind of fault. Yet § 1395gg(b)(1)(B) makes absence of fault a defense to recoupment. Moreover, to read this fine as the recoupment contemplated and limited by § 1395cc(a)(1)(B) suggests that providers could pass on to their patients this fine, levied only in lieu of expulsion from the Medicare program, if relevant determinations that

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[28] A related provision prohibits any Medicare payments to a provider or physician excluded after hearing from taking part in Medicare, § 1395y(d). The parties rely on the legislative history of this provision to illustrate what Congress intended with § 1320c-9(b)(3). This section and its history distinguish, as does § 1320c-9(b)(3), between mere rendering of an unnecessary service and "abuse"—"overcharging, furnishing excessive, inferior, or harmful services, or making a false statement to obtain payment." *See* S.Rept. 92-1230, 92d Cong., 2d Sess., p. 200 (1972); H.Rept. 92-231, 92d Cong., 1st Sess. pp. 98-99 (1971), U.S.Code Cong. & Admin. News 1972, p. 4989. *See also* the testimony of Social Security Administrator Robert H. Ball in House Ways and Means Committee *Hearings on the President's Proposals for Welfare and Social Security Amendments,* 91st Cong., 2d Sess., p. 154 (1970).

The lack of authority referred to in the committee reports, *e.g.,* S.Rept No. 92-1230 at p. 200, and by Commissioner Ball, was the lack of authority to withhold all future payments from particular providers who abused the program or endangered the lives of beneficiaries, that is, withholding amounting to total exclusion from the Medicare program. That is the authority HEW lacked prior to 1972 and that is the authority granted by Congress in §§ 1320c-9(b)(1) and 1395y(d). These references to a lack of authority to withhold future payments from such providers did not mean HEW could not withhold payments to offset any provider's liability to the program for prior erroneous overpayments.

services were not covered were made within three years of payment. This cannot be correct. The fine provided in § 1320c-9(b)(3) is a new liability, but it has nothing to do with the various limitations on liabilities in §§ 1395cc(a)(1)(B) and 1395gg(b) and (c), which were directed to the pre-existing right to recoup.

C. *Other provisions and recoupment*

1. Section 1395 provides, in part:

> Nothing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . .

The argument is made that subjecting hospitals to liability in recoupment for fees paid for unnecessary medical services would constitute interference with and supervision of the practice of medicine in violation of this section. Mount Sinai states that if HEW has the unlimited right to recoup contended for here that hospitals will of necessity "be constantly forced to second-guess the physicians on a virtually daily basis," that the "omnious ever presence of a wholesale recoupment power would create such a chilling effect . . . as to materially affect the ability and inclination of providers to act solely on the basis of the honest medical judgment of physicians" resulting, as a practical matter, in "interference with the practice of medicine."

Elsewhere the act provides for an immediate claims review system, § 1395f(a)(1). A doctor or other provider of medical services decides whether the service is covered, and it either pays or does not pay, as it decides, §§ 1395f(a)(1), 1395ff(a) and 20 C.F.R. § 405.701 *et seq.* Thus HEW must decide in every case whether to pay for the services. The immediate review system was enacted by the same Congress that enacted § 1395. It is not seriously contended that the statutorily-mandated system for immediate review constitutes the kind of interference with and supervision of medical care prohibited by § 1395. Post-payment recoupment is not shown to be more onerous than the immediate review system. We conclude that recoupment is not proscribed by § 1395.

2. There are features of the original Medicare Act which relate to recovering improperly disbursed funds, but none does so in such a way as to suggest that Congress had considered the matter and decided not to utilize the common law recoupment right. Thus, § 1395y(b) requires that all payments under Medicare be conditioned on reimbursement when the services have been paid for by a workmen's compensation plan. By contrast, the exclusions in § 1395y(a), *e.g.*, for medically unnecessary services and custodial care, are absolute. Payment is never permitted and there is no reference to subsequent reimbursment.

The difference has no implications for recoupment. The purpose of provisional payment is to leave the account open to allow for subsequent contingent events which bear on liability. Congress could easily perceive that whether a certain medical service would be paid for under a workmen's compensation act would be unknown and perhaps could not even be reasonably surmised at the time the Medicare claim was made. It thus authorized provisional payment but then also authorized recovery if workmen's compensation did pay. The § 1395y(a) excluusions, by contrast, are not amenable to provisional payment. Whether certain treatment reasonably appears to be medically necessary at the time of the provider's decision does not depend on later contingencies. Nor did Congress want to shift liability to beneficiaries because reasonable judgments of medical necessity prove ultimately to be erroneous.[29] There was thus no reason to authorize provisional payments and their recovery.

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[29] Of course, it may turn out that a certain treatment was not necessary because based on an erroneous diagnosis or for some other reason, but the proper test must be the reasonableness of the diagnosis and treatment at the time the diagnosis was made and the treatment decided upon.

In a like vein, the specific authority for after-the-fact adjustments for payments subsequently found to be erroneous under HEW's reasonable cost regulations does not suggest that other after-the-fact repayments or adjustments were not contemplated. The section authorizing such adjustments also authorizes interim estimated payments not less frequently than monthly, § 1395g. As the trial court noted, the authorization for adjustments for overpayments "simply recognizes and reconciles the conflicting demands of Section 1815 [§ 1395g] for periodic settlement of the reasonable cost due when the necessary data becomes available, yet for sufficient frequency of payment to generate an adequate cash flow for the provider." 376 F.Supp. at 1129.

To summarize, we hold that the government's common law right to recoup is available to HEW in its implementation of the Medicare hospital insurance program to recover from providers funds for medically unnecessary services.[30] The other questions posed by the parties' briefs to this court we leave to the District Court on remand.[31] We remand for further proceedings not inconsistent with this opinion

Reversed and remanded.

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[30] The result may be harsh at times. Congress has chosen to deal with that harshness by its 1972 amendments, in particular the amendments of §§ 1395gg(b) and (c).

[31] *See* footnote 1, *supra*.

APPENDIX

Court of Appeals Opinion on Rehearing

UNITED STATES COURT OF APPEALS,
FIFTH CIRCUIT.

No. 74-2154.

MOUNT SINAI HOSPITAL OF GREATER MIAMI, INC.,
Plaintiff-Appellee,

v.

CASPAR WEINBERGER, Secretary of Health, Education and Welfare, and Blue Cross of Florida, Inc., *Defendants-Appellants.*

* * *

Appeal from the United States District Court
for the Southern District of Florida.

On Petition for Rehearing and Petition for Rehearing En Banc

(Opinion 8-8, 1975, 5 Cir., 1975, 517 F.2d 329).

Before BROWN, Chief Judge, and GODBOLD and CLARK, Circuit Judges.

PER CURIAM:

The petition for rehearing and for rehearing en banc correctly points out that our original opinion was not consistent in its references to whether the beneficiary would be liable to a provider hospital if HEW made a determination that the services were not covered and then recouped from the provider. Our view is that the provider may turn to the patient as a possible source of payment. Whether the hospital, if it cannot get voluntary payment, may successfully sue the beneficiary will depend upon the extent to which the statutory scheme permits the provider to enter into a contract with the beneficiary by which the beneficiary undertakes that responsibility, and also upon the terms of any contractual arrangement actually made. We do not, and need not, decide on this appeal the interplay of statute and right to contract. The exposure of the

provider to the possibility of bearing the loss does not require us to hold that the Act does not permit inconsistent determinations of coverage or to hold that there can be only a single determination of coverage which binds everyone whether he is a party to it or not.[1] And, as we explained in the original opinion, Congress has to some degree ameliorated providers' exposure by giving them standing in the administrative determination of coverage questions and the right to judicial review. See footnote 22 and accompanying text.

Except to the extent that by this opinion we have modified our original opinion, the petition for rehearing is denied and no member of this panel nor Judge in regular active service on the court having requested that the court be polled on rehearing en banc (Rule 35 Federal Rules of Appellate Procedure; Local Fifth Circuit Rule 12) the petition for rehearing en banc is denied.

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[1] The beneficiary also labors under the threat of inconsistent determinations. Despite the fact that he receives services pursuant to a coverage determination, it may be later and inconsistently determined that there was an overpayment, and HEW may choose to collect by offsetting his Title II benefits. The second determination is made in a new proceeding, not a reopening or reconsideration of the original determinuation, § 1395gg(b) and (c) and 20 C.F.R. § 404.901 *et seq.*

APPENDIX

Constitutional and Statutory Provisions

CONSTITUTIONAL AND STATUTORY PROVISIONS

The Fifth Amendment to The Constitution of the United States provides, in pertinent part, as follows:

> No person shall be . . . deprived of life, liberty, or property, without due process of law . . .

The Health Insurance for the Aged Act ("The Medicare Act"), Pub. L. 89-97, §§ 100 *et seq.* (July 30, 1965), 79 Stat. 291, 42 U.S.C. 1395, as originally enacted provided in pertinent part:

> 42 U.S.C. 1395(a)(7) and (b):
>
> Except as provided in subsection (d) of this section, payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1395cc of this title and only if—
>
> • • •
>
> (7) with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1395x(k)(4) of this title) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or extended care facility, as the case may be, received notice of such finding.
>
> • • •
>
> (b) Reasonable cost of services.
>
> The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section

42 U.S.C. 1395(b)(cont.):

1395e of this title, be the reasonable cost of such services, as determined under section 1395x(v) of this title.

42 U.S.C. 1395y(a)(1):

Exclusions from coverage.

(a) Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B for any expenses incurred for items or services —

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a maliformed body member:

42 U.S.C. 1395ff:

Determinations; appeals.

(a) The determination of whether an individual is entitled to benefits under part A or part B and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Any individual with any determination under subsection (a) of this section as to entitlements under part A or part B, or as to amount of benefits under part A where the matter in controversy is $100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a

42 U.S.C. 1395ff (cont.):

hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

42 U.S.C. 1395gg(a)-(c):

Overpayments on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals.

(a) Any payment under this subchapter to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

(b) Where—

(1) more than the correct amount is paid under this subchapter to a provider of services or other person for items or services furnished an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or

(2) any payment has been made under section 1395f (e) of this title to a provider of services or other person for items or services furnished an individual.

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1937, as the case may be, or

(4) If such individual dies before such adjustment has been completed, to which any other individual is

42 U.S.C. 1395gg(b) (cont.):

entitled under subchapter II of this chapter or under the Railroad Retirement Act of 1937, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under subchapter II of this chapter.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1395i(g) of this title, and section 1395t(f) of this title, shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made.

(c) There shall be no adjustment as provided in subsection (b) of this section (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title) with respect to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of subchapter II of this chapter or would be against equity and good conscience.

* * *

The following provisions were among those added to the Medicare Act by Pub. L. 92-603 (Oct. 30, 1972), 86 Stat. 1385:

42 U.S.C. 1395 pp:

Limitation on liability where claims are disallowed—Conditions prerequisite to payment for items and services notwithstanding determination of disallowance

(a) Where—

(1) a determination is made that, by reason of section 1395y(a)(1) or (9) of this title, payment may not be made under part A or part B of this subchapter for any

42 U.S.C. 1395pp (cont.):

expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1395u(b)(3)(B)(ii) of this title, and

(2) both such individual and such provider of services or such other person, as the case may be, did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B of this subchapter.

then to the extent permitted by this subchapter, payment shall, notwithstanding such determination, be made for such items or services (and for such period of time as the Secretary finds will carry out the objectives of this subchapter), as though section 1395y(a)(1) of this title and section 1395a(9) of this title did not apply. In each such case the Secretary shall notify both such individual and such provider of services or such other person, as the case may be, of the conditions under which payment for such items or services was made and in the case of comparable situations arising thereafter with respect to such individual or such provider or such other person, each shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services or reasonably comparable items or services.

(b) in any case in which the provisions of paragraphs (1) and (2) of subsection (a) of this section are met, except that such provider or such other person, as the case may be, knew, or could be expected to know, that payment for such services or items could not be made under such part A or part B of this subchapter, then the Secretary shall, upon proper application filed within such time as may be prescribed in regulations, indemnify the individual (referred

42 U.S.C. 1395pp (cont.):

to in such paragraphs), subject to the deductible and coinsurance provisions of this subchapter, for any payments received from such individual by such provider or such other person, as the case may be, for such items or services. Any payments made by the Secretary as indemnification shall be deemed to have been made to such provider or such other person, as the case may be, and shall be treated as overpayments, recoverable from such provider or such other person, as the case may be, under applicable provisions of law. In each such case the Secretary shall notify such individual of the conditions under which indemnification is made and in the case of comparable situations arising thereafter with respect to such individual, he shall, by reason of such notice (or similar notices provided before the enactment of this section), be deemed to have knowledge that payment cannot be made for such items or services.

(c) No payments shall be made under this subchapter in any cases in which the provisions of paragraph (1) of subsection (a) of this section are met, but both the individual to whom the items or services were furnished and the provider of service or other person, as the case may be, who furnished the items or services knew, or could reasonably have been expected to know, that payment could not be made for items or services under part A or part B of this subchapter by reason of section 1395y(a)(1) or (a)(9) of this title.

(d) In any case arising under subsection (b) of this section (but without regard to whether payments have been made by the individual to the provider or other person) or subsection (c) of this section, the provider or other person shall have the same rights that an individual has under section 1395ff(b) of this title (when the determination is under part A) or section 1395(b)(3)(C) of this title (when the determination is under part B) when the amount of benefit or payments is in controversy that such rights may, under prescribed regulations, be exercised by such provider or

42 U.S.C. 1395pp (cont.):

other person only after the Secretary determines that the individual will not exercise such rights under such sections.

42 U.S.C. 1320c-9:

Obligations of health care practitioners and providers of health care services—Enumeration of obligations

(a)(1) It shall be the obligation of any health care practitioner and any other person (including a hospital or health care facility, organization, or agency) who provides health care services for which payment may be made (in whole or in part) under this chapter, to assure that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this chapter—

(A) will be provided only when, and to the extent, medically necessary; and

(B) will be of a quality which meets professionally recognized standards of health care; and

(C) will be supported by evidence of such medical necessity and quality in such form and fashion and at such time as may reasonably be required by the Professional Standards Review Organization in the exercise of its duties and responsibilities:

and it shall be the obligation of any health care practitioner in ordering, authorizing, directing, or arranging for the provision by any other person (including a hospital or other health care facility, organization, or agency), of health care services for any patient of such practitioner, to exercise his professional responsibility with a view to assuring (to the extent of his influence or control over such patient, such person, or the provision of such services) that such services or items will be provided—

(D) only when, and to the extent, medically necessary, and

(E) will be a quality which meets professionally recognized standards of health care.

42 U.S.C. 1320c-9 (cont.):

(2) Each health care practitioner, and each hospital or other provider of health care services, shall have an obligation, within reasonable limits of professional discretion, not to take any action, in the exercise of his profession (in the case of any health care practitioner), or in the conduct of its business (in the case of any hospital or other such provider), which would authorize any individual to be admitted as an inpatient in or to continue as an inpatient in any hospital or other health care facility unless—

(A) inpatient care is determined by such practitioner and by such hospital or other provider, consistent with professionally recognized health care standards, to be medically necessary for the proper care of such individual; and

(B)(i) the inpatient care required by such individual cannot, consistent with such standards, be provided more economically in a health care facility of a different type; or

(ii) (in the case of a patient who requires care which can, consistent with such standards, be provided more economically in a health care facility of a different type) there is, in the area in which such individual is located, no such facility or no such facility which is available to provide care to such individual at the time when care is needed by him.

(b)(1) If after reasonable notice and opportunity for discussion with the practitioner or provider concerned, any Professional Standards Review Organization submits a report and recommendations to the Secretary pursuant to section 1320c-6 of this title (which report and recommendations shall be submitted through the Statewide Professional Standards Review Council, if such Council has been established, which shall promptly transmit such report and recommendations together with any additional comments and recommendations thereon as it deems ap-

42 U.S.C. 1320c-9 (cont.):

propriate) and if the Secretary determines that such practitioner or provider, in providing health care services over which such organization has review responsibility and for which payment (in whole or in part) may be made under this chapter has—

(A) by failing, in a substantial number of cases, substantially to comply with any obligation imposed on him under subsection (a) of this section, or

(B) by grossly and flagrantly violating any such obligation in one or more instances,

demonstrated an unwillingness or a lack of ability substantially to comply with such obligations, he (in addition to any other sanction provided under law) may exclude (permanently for such period as the Secretary may prescribe) such practitioner or provider from eligibility to provide such services on a reimbursable basis.

(2) A determination made by the Secretary under this subsection shall be effective at such time and upon such reasonable notice to the public and to the person furnishing the services involved as may be specified in regulations. Such determination shall be effective with respect to services furnished to an individual on or after the effective date of such determination (except that in the case of institutional health care services such determination shall be effective in the manner provided in subchapter XVIII of this chapter with respect to terminations of provider agreements), and shall remain in effect until the Secretary finds and gives reasonable notice to the public that the basis for such determination has been removed and that there is reasonable assurance that it will not recur.

(3) In lieu of the sanction authorized by paragraph (1), the Secretary may require that (as a condition to the continued eligibility of such practitioner or provider to provide such health care services on a reimbursable basis)

42 U.S.C. 1320c-9 (cont.):

such practitioner or provider pay to the United States, in case such acts or conduct involved the provision or ordering by such practitioner or provider of health care services which were medically improper or unnecessary, an amount not in excess of the actual or estimated cost of the medically improper or unnecessary services so provided, or (if less) $5,000. Such amount may be deducted from any sums owing by the United States (or any instrumentality thereof) to the person from whom such amount is claimed.

(4) Any person furnishing services described in paragraph (1) who is dissatisfied with a determination made by the Secretary under this subsection shall be entitled to reasonable notice and opportunity for a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of his title.

(c) It shall be the duty of each Professional Standards Review Organization and each Statewide Profesisonal Standards Review Council to use such authority or influence it may possess as a professional organization, and to enlist the support of any other professional or governmental organization having influence or authority over health care practitioners and any other person (including a hospital or other health care facility, organization, or agency) providing health care services in the area served by such review organization, in assuring that each practitioner or provider (referred to in subsection (a) of this section) providing health care services in such area shall comply with all obligations imposed on him under subsecion (a) of this section.